reviews

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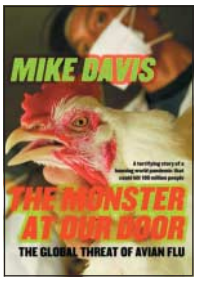
The Monster at Our Door: The Global Threat of Avian Flu

Mike Davis



The New Press, £12.99, pp 212
ISBN 1 59558 011 5

Rating: ★★☆☆

Is the threat of avian flu "the monster at our door" or, to use an alternative and zoologically mixed metaphor, a frightened chicken crying wolf? We need to know.

Now, as throughout the past few decades, the health scare industry continues to cut dark swathes through the sunny fields of reason, evidence, and proportionality. The MMR (measles, mumps, rubella) vaccine, mercury in tooth fillings, listeria, mobile phones, microwave ovens, beef, coffee, electromagnetic fields, pesticide residues, and a score of other such items have clawed their way up the news agenda, basked in the media spotlight, then slipped back to their true level in the league table of environmental risk. The number of times that some of these items have made the return trip would lead one to believe they must have purchased a season ticket.

In recent weeks, a few world-weary commentators have begun hinting that avian flu will soon be joining that dismal list. Remember severe acute respiratory syndrome (SARS), they say. We heard all the same stuff about a pandemic, all the same horror stories about deaths running into millions. But the containment measures worked; the international public health system triumphed. In the end SARS killed fewer than 800: small beer by comparison with the mortality attributable to normal flu in a normal year. So why should this latest viral threat be any different?

If we do label avian flu as the next "scare that never will be," and if we do start to scorn the efforts of the public health authorities to prepare for it, we may find ourselves making a grievous error. The point was made last year in a review of the 2002 SARS outbreak by Professor Roy Anderson and colleagues from the department of infectious diseases at Imperial College, London (*Philosophical Transactions of the Royal Society B: Biological Sciences* 2004; 359: 1091-105). As they say, the low transmissibility of the SARS virus, combined with the fact that victims didn't reach peak infectiousness until they were already showing clinical symptoms, made it feasible to control the epidemic using public health measures such as isolating patients and quarantining their contacts.

Speaking to a meeting about SARS organised by the Royal Society, Professor Anderson added that while draconian public health measures might be relatively simple to implement in China, it was difficult to be certain that North Americans and western Europeans would be equally compliant in the face of demands for mass quarantine. In the next global epidemic we may not be so lucky—biologically or geographically.

In the light of all this, the timely appearance of a popular book on avian flu ought, you might think, to be welcomed. Its author, Mike Davis, has achieved every publisher's dream: a book ready to be released at precisely the time when its subject matter is making headlines. And given the leisurely pace of publishing, this volume is as up to date as you could hope for; the most recent references are from April.

The book highlights what Davis sees as some of the errors that have been made in dealing with previous outbreaks of infectious disease, points to the current lack of commercial enthusiasm for vaccine development, and regrets the failure of international public health to keep up with the galloping pace of globalisation.

He also draws attention to the bizarre research priorities that operate in Bush's America with its obsession over homeland security. To the current US administration, the significance of any particular threat appears to be judged not by the damage it might cause, but according to its origin: manmade as opposed to natural. All sorts of people doing all sorts of research in America have recently "discovered" that their work has hitherto unnoticed implications for homeland security—for which the supply of funds seems to be virtually inexhaustible. Microbiologists have, quite reasonably, not refrained from enjoying this largesse; but neither avian nor any other form of influenza ranks high in the terrorists' biological weapons catalogue. Davis quotes the plaintive comment of one expert: "It's too bad that Saddam Hussein's not behind influenza."

The relative insouciance with which recent US governments have treated the prospect of a flu pandemic is difficult to fathom. All public health schemes, of course, reek dangerously of "socialised medicine." By contrast, anyone struggling against a terrorist assault on wellbeing can wrap Old Glory around the enterprise and claim the immunity conferred by displays of patriotic fervour.

The Monster at Our Door has come at precisely the right time; whether it is also precisely the right book is another matter. The basic virology in the early chapters is not well explained, and creates the impression of an author impatient to move swiftly through it and get on to the more polemical stuff that is closer to his heart. Mike Davis comes brandishing a certain reputation—as the jacket of the new book makes no effort to conceal. "The United States' most engaging prophet of doom," runs one of the comments on his previous work. And the front of the jacket is illustrated with a malevolent looking chicken gazing beadily over the word "monster" in the book's title.

Avian flu deserves to be taken seriously. But when the facts themselves are so chastening, any attempt to overexcite them is likely to prove counterproductive.

VALERY HACHE/AFP/GETTY

Has public health failed to keep up with globalisation?

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The Swine Flu Affair: Decision-Making on a Slippery Disease

Richard E Neustadt, Harvey V Fineberg

University Press of the Pacific, $27.50, pp 204
ISBN 1 4102 2202 0

Rating: ★★★★

In January 1976 an outbreak of upper respiratory disease occurred at Fort Dix, a military base in New Jersey. The state's chief epidemiologist made a bet with the medical officer in charge at Fort Dix that it was in the midst of a flu epidemic. To settle the wager the medical officer sent cultures to the state laboratory. He lost. The cultures showed an unidentified flu virus, which was sent to the Centers for Disease Control and Prevention (CDC) in Atlanta and turned out to be swine flu.

At that time any antigenic shift, as was shown in this case, was believed to be the possible forerunner of a pandemic. The then director of CDC, David Sencer, prepared a memorandum for David Mathews, secretary of health, education, and welfare at the time. The memorandum offered four options of a common sort in government: three framed to be rejected by the reader and a fourth one desired by the writer.

The first was "do nothing," the second was "minimal response," the third was a "government program," and the fourth was a "combined approach," which added a role for the private sector. This memorandum of action was deliberately designed to force a favourable response from a beset administration, which could not afford to turn it down and then have it leak. The memorandum was presented at a meeting with Mathews on 15 March, where Sencer pressed Mathews hard. Mathews felt that even had the risk seemed far away, it was politically impossible to say no. Although the risks were slight, Sencer pushed the strong possibility of a pandemic related antigenically to the 1918 flu. A decision had to be made within two weeks to give time for the preparation, testing, and administration of the vaccine before the next flu season.

Theodore Cooper, assistant secretary of health, education, and welfare, was impressed and made Sencer's cause his own.

On 22 March a meeting was held by President Ford, attended by Mathews and Cooper, and other members of the administration. The president was not warned about six things: trouble with serious side effects, with children's dosages, with liability insurance, with expert opinion, with the public health service's public relations, and with his own credibility. The vaccine was presumed to be safe and efficacious.

On 24 March at 3 30 pm another meeting was held in the cabinet room with outside scientists, including the inveterate opponents Jonas Salk and Albert Sabin. Summoned to the White House at short notice and overawed, most of those present took it to be "programmed" and "a stage set" and that the decisions had been taken. They felt that "We were used." A show of hands showed unanimous approval for the programme. Ford asked for any dissent, but there was none. The president then said he would suspend the meeting and go to the Oval Office, where anyone who had doubts could talk to him privately. Nobody did. The president went back to the cabinet room, collared both Salk and Sabin, and went to the press room, where he announced the $135m (£79m; €115m) programme of swine flu vaccination to inoculate every man, woman, and child in the country.

The rest of the story is well known—the problems of manufacture, the refusal of the insurance companies to issue liability policies, the public's only moderate response to the vaccination programme, the occurrence of Guillain-Barré syndrome and, most noticeable of all, the non-occurrence of an outbreak of swine flu. The whole affair, so well described in this book, is a good example of the fallibility of expert opinion and the fallibility of government.

The Swine Flu Affair, by members of the Harvard Schools of Government and Public Health, was commissioned by the health, education, and welfare secretary Joseph Califano and first published in 1978. Nevertheless it is racily written and holds the reader's attention as well as any good detective or science fiction novel. It should be required reading for doctors and politicians, as the US government faces the same problems today as it did nearly 30 years ago.

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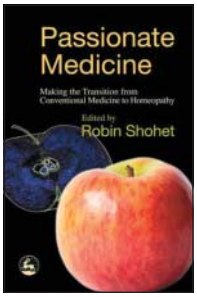
Passionate Medicine: Making the Transition from Conventional Medicine to Homeopathy

Ed Robin Shohet



Jessica Kingsley, £9.95/$28.95, pp 192
ISBN 1 84310 298 6
www.jkp.com

Rating: ★★★★

Passionate Medicine's contributors are five doctors and two vets who struggled with the practice of conventional medicine and found a more natural home in homoeopathy. Together they form the Homeopathic Professionals Teaching Group and teach homoeopathy to professionals in Britain and abroad. Their teaching methods are unusual in having a strong emphasis on self awareness and development of the health professional, and they "walk their talk" in having a regular supervision group themselves, which is run by Robin Shohet, the book's editor.

The authors, six men and one woman, tell their stories: how they came to study medicine and veterinary medicine; and their shock at discovering that it was not, as they had assumed for various reasons, a training in caring but, as one of them, Alice Greene, writes, "a tortuous test in chemistry, physics and statistics—a world away from my simple notion of what a doctor needed to know."

Several talk of their early experiences of human dissection, raising the possibility that this is a kind of initiation test for trainee doctors, a first lesson in dealing with your feelings and pretending you don't have any. All the contributors talk of the experience of human suffering and death that they encountered during their early days as qualified doctors and how the feelings of the professional involved were never acknowledged, let alone discussed.

These seven clinicians are remarkable in not having been prepared to make the compromises that modern medicine required of them. Most of their stories have a strong spiritual theme. As Brian Kaplan says, "Each has a story, a journey different from mine, but we always share one thing in common. We have taken a leap of faith and followed where our hearts have led us."

This book makes a real attempt to explain homoeopathy beyond the superficial knowledge most of us have, and it raises interesting questions about ourselves and our own lives. On the one hand it is amazing to hear doctors rue the lack of discussion of feelings. On the other you can't help thinking how extraordinary it is that clinicians studiously avoid the questions of life and death they face every day.

Doctors sceptical of homoeopathy may find themselves wondering how such intelligent and articulate people can be proponents. For all doctors this book has the potential to raise searching questions, especially for those who feel that they did lose something of themselves when they first entered the dissecting room.

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How the media caught Tamiflu

From a bit of a dud to the world's most sought after drug in the space of six months, surely Roche cannot believe its luck with oseltamivir (Tamiflu). Despite a silly name and a lack of convincing evidence that it will have any real impact on an influenza pandemic, sales and recognition of the drug frequently dubbed "our best hope against bird flu" have leapt through the roof.

Between 1999 and 2002 Roche sold just 5.5 million treatments. Next year the total sales of oseltamivir are projected at 150 million. Roche's share price has soared this year by 60%.

Sir Liam Donaldson, England's chief medical officer, has noted that doctors have little idea how effective oseltamivir antiviral tablets would actually be during a pandemic.

But this has not affected demand and Roche cannot make the drug quickly enough for the 50 countries currently stockpiling it. On the internet Tamiflu is trading at five times its retail price.

Of course in large part Roche has Mother Nature to thank for the turn of events. The rising spectre of an influenza pandemic and no immediate vaccine to fight it has made bird flu the medical story of the year and given Tamiflu a public profile comparable to that of Viagra.

But that's not the whole story. Roche has naturally made the most of this golden opportunity and its public relations machine has naturally milked Tamiflu for all it was worth.

Like most other drug companies, its marketing department uses opinion leaders—usually professors or senior doctors from medical schools who can provide the credibility that company representatives cannot. In the case of oseltamivir, it is Professor John Oxford of Queen Mary College, London, who has led the drug's endorsement.

CHRIS RAOBURN/PA/EMPICS/PA

He routinely provides the media with positive comments about Tamiflu and has even appeared in promotional videos for the drug. However, his ties to Roche are rarely if ever mentioned in the mainstream press. He is also the scientific director of and a share owner in Retroscreen Virology, which has had contracts with Roche.

As a media pundit he denies any conflicts of interest. He told the *BMJ*: "I believe these drugs are very useful and I've also worked with Johnson and Johnson and Glaxo (firms that make rival treatments). I've not tried to conceal anything. But you can't mention all your grants and links every time you appear on the television or every time you're quoted, there just isn't enough time."

But other doctors believe opinion leaders should make time to do this. Joe Collier, professor of medicines policy at St George's Hospital Medical School, London, and a former editor of the *Drug and Therapeutics Bulletin*, said, "It's a real dilemma who to believe." He said that an opinion leader might be totally impartial but on the other hand he or she might not.

"The fact is we have to be suspicious," Professor Collier said, adding, "Perhaps the media should speak to more than one person when it's looking for comments or information. Somehow the mainstream media needs to think more on what it's going to do about this."

Respected figures in medical research, such as Professor Colin Blakemore, the chief executive of the Medical Research Council, have noted the need for leading doctors to work closely with industry to facilitate drug development. But surely this doesn't abrogate doctors' responsibility to be transparent about the nature of that relationship—nor does it relieve the press of its duty to alert readers to potential conflicts of interest.

For several years I worked as medical correspondent at *New Scientist* magazine, where it was standard practice to seek several opinions on a single issue. When I moved from this ivory tower to Fleet Street I was somewhat taken aback at the "any ologist will do" attitude when obtaining quotes for a story—although I soon became aware of the time constraints that made this necessary.

Another Fleet Street health correspondent whom I spoke to this week said, "When you've got three articles to write in an afternoon and news desk shouting at you for copy, you just want to get a quote that you need to make the story; the last thing on your mind is checking the background of everyone you've quoted."

The correspondent added, "Anyway, how do we know that any doctor hasn't benefited financially from a drug company; I'm not sure there are that many left who haven't."

A spokesman for the drug industry's UK umbrella group, the Association of the British Pharmaceutical Industry, denied the media was being manipulated. "In fact I think there's a sense that journalists will usually ring the person they think will give them the quote they want."

Alessandro Liberati and Nicola Magrini, writing in the *BMJ* two years ago, called on opinion leaders to avoid "double standards" and adopt the same rigorous ethics and transparency when speaking to patients and policy makers that they would be expected to show when writing for peer reviewed journals (*BMJ* 2003;326:1156-7).

You might add that newspapers and broadcasters will need to raise their game, as well. And so far the signs are not good.

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Hit parade bmj.com

These articles scored the most hits on the *BMJ*'s website in their first week of publication

OCTOBER

1 **Editorial: ASCOT: a tale of two treatment regimens**
BMJ 2005;331:859-60
7795 hits

2 **Editorial: Bird flu and pandemic flu**
BMJ 2005;331:975-6
7137 hits

3 **News: Do GPs deserve their recent pay rise?**
BMJ 2005;331:800
6101 hits

4 **Editorial: Sports utility vehicles and older pedestrians**
BMJ 2005;331:787-8
4339 hits

5 **Editor's choice: Evidence not ideology**
BMJ 2005;331 (8 October)
4107 hits

6 **Clinical review: The patient's journey: rheumatoid arthritis**
BMJ 2005;331:887-9
3268 hits

7 **Editorial: Cervical cancer, human papillomavirus, and vaccination**
BMJ 2005;331:915-6
3166 hits

8 **This week in the *BMJ*: Obesity begins in infancy**
BMJ 2005;331 (22 October)
3149 hits

9 **Paper: Being big or growing fast: systematic review of size and growth in infancy and later obesity**
BMJ 2005;331:929
3054 hits

10 **Education and debate: Statistics notes: Standard deviation and standard errors**
BMJ 2005;331:903
3050 hits

All articles cited are full text versions.

PERSONAL VIEWS

Is it time to ban dogs as household pets?

See *Letters*, p 1269

After tobacco, alcohol, and sports utility vehicles, how long will it be before public health experts get serious about the menace of widespread dog ownership? Despite ongoing research into dog bites and zoonoses, the occasional media outcry about pit bull terrier and rottweiler maulings, and legislation such as the United Kingdom's Dangerous Dogs Act of 1991, pet dogs and their owners have mostly been given a rather long leash. And yet it increasingly seems extraordinary to me—considering all the things that the law prevents us from doing—that it is legal for people to keep a potentially dangerous wild animal in their home. Or even, as many postmen and postwomen have discovered to their cost, in their front gardens.

In 2003 the UK had about 6.5 million dogs, estimates the Pet Food Manufacturers' Association (www.pfma.com/public/petownership_stats.htm), although the abolition of the dog licence under Mrs Thatcher's government in 1987 has hampered the collection of data on ownership. That is roughly one dog for every 10 people. (A crude survey among my *BMJ* colleagues found that, of 35 who replied to an email question, seven were dog owners, double the proportion in the country as a whole.) The only requirement by law in England and Wales is that dogs must wear a collar in public bearing its owner's name and address, although bylaws allow local authorities to exact penalties for fouling pavements and persistent noise nuisance.

My school debating society in the mid-1970s considered the motion "This house believes that dogs should be banned as household pets." At the time I thought what an absurd idea—how on earth could anyone ban domestic dog ownership and why ever would they want to? Nor did I feel especially sorry for the proposer and seconder when they lost abysmally and were almost booed out of the debating chamber. Yet now—after having twice narrowly escaped finger amputation by canine and after years of negotiating London's turd smeared streets—it seems that my schoolfellows were way ahead of their time.

The charge sheet against dog ownership is long, but as far as public health is concerned the main problems are the two Fs: fangs and faeces. Dog bites are an important source of injury, particularly among children (*JAMA* 1998;279:51-3). It is estimated that there are around 200 000 dog bites in the UK each year (www.patient.co.uk/showdoc/23068877/). Although fatalities from dog bites are extremely rare, there is a risk of minor infection with a range of pathogens (*New England Journal of Medicine* 1999;340:85-92). In countries where rabies is endemic, the risks are much greater. As well as the risk of physical scarring, dog bites can also have psychological consequences (*BMJ* 1991;303:1512-3).

The Dangerous Dogs Act, a response to several high profile fatal maulings in Britain in the late 1980s, was much derided as unworkable. But I think the problem with the act—which singled out four breeds of fighting dog—is that it did not go far enough. All dogs are potentially dangerous, not just pit bulls and Japanese tosas. Even those cuddly little white Scottie dogs could inflict nasty injuries on a baby or a toddler. A *BMJ* study in the early 1990s found that the types of dog most commonly responsible for bites were Staffordshire bull terriers, Jack Russells, medium sized mongrels, and Alsatians, none of which are listed in the act (*BMJ* 1991;303:1512-3).

Two of the greatest contributions to public health were the invention of the flush toilet and the construction of sewers, but with dogs we remain always back at square one. Cute Labrador puppies might help sell toilet rolls on UK television, but sadly that's as far as it is ever going to go on the dog and lavatory front. "Responsible" owners clean up their animal's mess. But that just means our parks are now full of special bins containing flimsy plastic bags packed with excrement. And dog mess is not just unpleasant, it is sometimes (when pets are not wormed) a source of toxocariasis, which can lead to blindness in children.

So much for fangs and faeces. Then there is the barking. A friend of mine had his sleep disturbed nearly every night for two years by the yelping of a neighbour's Alsatian. The poor animal was kept on a tiny balcony 24 hours a day. Local environmental health officers wanted to act but could do so only if they witnessed the dog barking. And that took two years of trying, two years of broken sleep, two years of my friend phoning the council's noise patrol service in the small hours and waiting for its officers to visit. This problem is far from unusual. A quick internet search shows that local authorities the world over have policies for handling complaints about canine control.

I am not a dog hater—far from it. Some of my best friends are dogs (and they won't mind me saying so). I would probably even quite like a dog, if the non-defecating, non-barking, non-biting species could be bred. As well as the obvious value of guide dogs and hearing dogs, and other working dogs (police dogs, bomb sniffers, drug sniffers, sheep dogs), dog ownership is apparently good for lowering blood pressure, encouraging exercise, and combating loneliness. Research published by the *BMJ* has also indicated that dogs can smell out cancer (*BMJ* 2004;329:712). Perhaps we should look forward to a time when "man's best friend" is available only on prescription?

The usual rejoinder to complaints about dog behaviour is that it is the owners, and not their pets, that are to blame—which is precisely why dog ownership should be curbed. We need responsible dog owners, people say. Call me dogmatic, but responsible dog ownership is mostly a contradiction in terms—at least in our inner cities.

Perhaps it is still too soon to go as far as those daring speakers at my school debating society urged and ban dogs as household pets. Besides, the coercive approach generally doesn't work. But it is clear that although dog ownership in general is not nearly as dangerous as driving, for example, it still carries plenty of risks. So why do we take dog ownership for granted? Why, instead, don't we introduce a dog ownership test, with a minimum age and a licence?

I have no desire to upset assorted canine lobbies. I merely wish to raise a question that I think anyone who cares about public health, environmental health, and quality of life should be able to engage with dispassionately. Or am I just barking?

ALAN POWDRILL/PHOTONICA/GETTY

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Competing interest: TJ has donated money to the charity Hearing Dogs for Deaf People.

The age of entitlement

See *News*, p 1255

"If I fulfil this oath and do not violate it, may it be granted to me to enjoy life … if I transgress it and swear falsely, may the opposite of all this be my lot." My thumping hangover didn't help on my graduation day. I flushed, sweated, and suppressed wave on wave of nausea. I was a cloaked polyester angel alongside 200 other gowned students in a large university hall. We stood, electricity crackling, and recited an oath before we were ushered through for graduation—I can't remember what we said or even if it was in English—but we glibly took that oath. A friend turned and said, "It's all Greek to me," and we both laughed. Now in these faithless days the notion of an oath or even of vocation have little relevance. We are a detached and fractionated profession; conversations focus on "time limited contracts," no payment, no work, study leave, and so on, and a sense of entitlement pervades everywhere.

I spent 10 years in inner city medicine. I commuted from my five bedroom suburban home in my Golf GTi. I enjoyed the hospitality of the drug industry—meals, freebies, flattery, and money. It was comfortable and complacent. My own hospitality paled in comparison with the stories that circulated in medical circles, but my sense of entitlement rationalised this greed and excess as harmless and acceptable. However, that "Greek" kept nagging in my subconscious. Finally my wife gave voice to what I knew to be true: that we were lost. For my penance I decided to bear witness to what I had seen.

Blame is in the nature of humanity. It was the drug companies' fault, I reasoned—avaricious, secretive, manipulative, capitalist, spinning research, abusing charities, and disease mongering. The industry was an evil empire whose public standing had reduced to that of tobacco companies, its roots in innovation and research long forgotten. Beyond salvation?

In response to this image the Association of the British Pharmaceutical Industry (ABPI) has launched a new code of practice. Its core features include promotion of adverse drug reporting by patients, a commitment to openness between the industry and charities, and naming and shaming companies that breach the code. Also, doctors will now have to slum it in economy class, and "lavish venues" are out—a tacit admission of the excess of the past. The code is still not actively enforced and has no financial censor. A strong argument remains that ABPI is not capable of regulating this multibillion pound business and that responsibility should pass to an independent body. Only time will tell if the hospitality culture is really over or if this is mere expedient window dressing. The ABPI, however, should be given the benefit of the doubt for now; moreover, as its director, Richard Barker, ruefully remarked, "It takes two to tango." He is right. For too long we have hidden behind our professionalism and projected ourselves as naive victims in all this. We are not victims, but we have been at best thoughtless and at worst utterly selfish, lapping up the hospitality even though we knew it was inappropriate. We have tarnished our profession, and it is little wonder that our status has fallen.

Commitment, duty, service, and caring are our lineage. We were mostly trained by the state, and many of us received maintenance grants to allow us to study. We earn good salaries, enjoy full employment, and have generous holidays, sickness protection, and an enviable index linked pension. We are privileged public servants and should be grateful. Forget the puff, the feigned wounded indignation, and the idea that somehow because we are the academic elite we are different—we are not. Professionalism is neither passive nor a right but must be actively shown.

> We have tarnished our profession, and it is little wonder that our status has fallen

The industry has moved and accepted responsibility. It is now time for the General Medical Council to act and issue specific guidance on acceptable levels of contact with the industry, hospitality, and transparency in all financial dealings. It is only what the public deserves and expects of all public servants. The statement "You must act in your patients' best interests … you must not ask for or accept any inducement, gift, or hospitality which may affect or be seen to affect your judgement" is simply not enough.

If we want to be more than just bystanders in the march towards medicalisation and inappropriate polypharmacy then we need a new, mature, and equal relationship with the drug industry. A time bomb of resentment is ticking among children and adults who are subjected to this medicalisation and who may well in time view doctors as nothing more than weak collaborators.

The party's over and now it's time to deal with our collective hangover. We may be flushed, sweating, and suppressing wave on wave of nausea at the thought. The new ABPI code is now on general release in a health centre and hospital near you, and in the words of a modern day icon, Albus Dumbledore of Harry Potter fame, "You have to make a choice between what is right and what is easy."

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Competing interest: DS is the UK spokesperson of No Free Lunch (www.nofreelunch.uk.org)

SOUNDINGS

Ghosts

The decay of Africa's health care has taken place in stages, each stage corresponding to the development theory that was fashionable at the time.

The first theory saw development in purely economic terms and proposed that African countries—where medicine was district hospital and health centre based—should follow the path that Europe and America had taken. The result was the construction of sophisticated teaching hospitals and the introduction of Western style specialisation.

When it was recommended that industrialisation should drive development, the rate of urbanisation increased, slums appeared, and tertiary hospitals were overwhelmed and could not accept referrals.

In the 1960s sociologists joined the development teams and "cultural heritage" had to be respected. The bare foot doctor, the herbalist, and the traditional birth attendant had their day, and the warm word "community" gained currency.

Health centres and district hospitals were still built, but as the teaching hospitals and the just established postgraduate training were Western oriented the graduates could no longer cope with the disease patterns typical of a district hospital.

The development backlash came in the 1970s, from among the African intelligentsia, who discovered "neocolonialism" and a "false paradigm" in every move of the West and of the international agencies. The "dependency theory" became the bogeyman. The medical profession was ostracised for "Western leanings."

In the wake of Mrs Thatcher and President Reagan the last remnants of free medical care were disassembled and the medical profession was encouraged to engage itself in the commercial sector.

In the 1990s the prevalent developmental theory spoke of "district focus" and "endogenous growth," but these words had no effect on the now dilapidated and deserted district hospitals. By this time the teaching "centres" were also decaying and, as the teachers were busying themselves in the private hospitals, the students and the postgraduates were left with the internet preaching Western "gold standards."

Already one wonders whether the millennium goals and the spirit of Gleneagles are just another set of ghosts.

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